Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-0126-01

MFDR Date Received
September 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent a status request and a request for reconsideration, which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.240."

Amount in Dispute: $106.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the carrier representative box 15, Downs Stanford on September 14, 2011. The insurance carrier representative picked up and initialed for the DWC060 on September 14, 2011, by "B.S." The division, will therefore issue a decision based on the information available for review at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2011	99213	$106.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The requestor did not provide a copy(s) of EOB's with the DWC060 request.

Issues

1. Did the requestor obtain a denial from the insurance carrier for disputed date of service June 24, 2010?
2. Did the requestor meet the requirements of Rule 133.307?
3. Is the requestor entitled to reimbursement?

Findings

1. Former 28 Texas Administrative Code §133.307(c)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).
2. Former 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement including "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
3. Former 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not explained the reasons that the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).
4. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issues including "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
5. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.